M•Plan Benefits & Services

State of Indiana Plan III

Deductible	**Member Cost**
Single	$500
Family	$1,000
Maximum Out-of-Pocket	
Contract Year Maximum Out-of-Pocket per Covered Person	$2,500
Contract Year Maximum Out-of-Pocket per Family	$5,000
Flat dollar copays and copays and coinsurance for prescription or biopharmaceutical drugs & products do not count toward the satisfaction of the out-of-pocket maximum.	
Physician Office Services	
Primary care physician office visits	$20 per visit
Visits to specialist upon referral	$30 per visit
Services include: Periodic physician check-ups and exams; prenatal and postnatal maternity care; well child care and routine pediatric visits; immunizations and injections; allergy tests and treatment; hearing exams; casts and dressings; care of immediate medical needs	
Primary care, specialty and referral physician in-home visits	$25 per visit
Physician Hospital Services	
Physician services for surgery, visits and examinations	20% of covered charges
Inpatient Hospital Services	
Semi-private room and board	20% of covered charges
Services include: Private room if medically necessary, operating, recovery rooms and other special units including intensive care, maternity care, hospital ancillary services including laboratory, x-ray, EKG and other diagnostic services, other services including anesthesia, physical therapy and medications, administration of blood and blood plasma, non-experimental organ transplants	
Outpatient Services	
Outpatient surgery	20% of covered charges
Other outpatient services including laboratory, x-ray, EKG and other diagnostic services	20% of covered charges
Other outpatient services for MRI, CT, PET and SPECT	20% of covered charges
Emergency room services for life-threatening medical emergencies worldwide	$150 per visit *(waived if admitted to hospital)*
Immediate/urgent care center visit	20% of covered charges
Mental Health Services	
Inpatient mental health services	20% of covered charges
Outpatient visits for short-term psychotherapy, partial hospitalization or day treatment, crisis intervention or psychiatric testing Psychiatric Intensive Outpatient Program (Ambulatory Level Two Mental Health Programs)	$20 per visit
Substance Abuse Services	
Inpatient substance abuse services or chemical dependency for diagnosis/short-term evaluation or crisis intervention and detoxification	20% of covered charges
Outpatient visits per contract year for Chemical Dependency or Substance Abuse Services; Intensive Outpatient Program Services. Services for alcoholism, drug abuse and addiction shall be limited to diagnosis, evaluation and treatment for detoxification	$20 per visit
Other Services	
Allergy serum	50% of covered charges
Dialysis	$30 per visit and 20% covered charges
Durable medical equipment	50% of covered charges
Emergency ambulance	20% of covered charges
Home Health Care	20% of covered charges; limited to a maximum combined benefit of 160 days with Skilled Nursing per contract year
Morbid Obesity Surgery	20% of covered charges per (weight-loss) surgery
Prosthetic devices and corrective appliances	50% of covered charges
Rehabilitation Therapy - Occupational, Physical and Speech	Inpatient – 20% of covered charges; Outpatient - $20 copay; limited to 60 visits of combined inpatient and outpatient services per contract year
Skilled Nursing Facility Services	20% of covered charges; limited to a maximum combined benefit of 160 days with Home Health per contract year
Transplants	20% of covered charges
Prescription Drugs	
Prescription drugs for up to 30-day supply. OTC Select, Generic and Select Prescription Drugs are available through the participating mail order pharmacy for two thirty (30) day supply copayments for a 90-day supply. Non-Select is available for three thirty (30) day supply copayments for a 90-day supply. To be covered, certain prescription drugs may require Prior Authorization.	
OTC Select Drugs	$ 5 copay
Generic prescription drugs	$10 copay
Formulary Brand Name Drugs and Formulary Diabetic Supplies	$20 copay
Brand Name or Generic Non-Formulary drugs	40% of covered charges ($40 minimum, $100 Maximum)
Biopharmaceutical drugs/injectable drugs	20% of covered charges
Diaphragms, cervical caps	20% of covered charges

$1 Million Lifetime Maximum Benefit per Covered Person

All services must be provided or referred by the Member's Participating Primary Care Physician and Prior Authorized by the Network, except in cases of life-threatening emergency.

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Exclusions

- Any service not provided, arranged for or referred by the Member's Primary Care Physician and Prior Authorized or approved by the Member's Network except for life-threatening emergency
- Any service not medically necessary or authorized
- Services for which coverage is provided or is required to be provided by law in a public/government facility
- Personal comfort or convenience items in and out of the Hospital such as Convenience Packaging, television, telephone, private room (unless Medically Necessary), housekeeping, homemaker service, and room and board as part of Home Health Care.
- Custodial care, nursing home care, rest cures, domiciliary care regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities.
- Physical exams required by a third party (e.g. employment, insurance, licensing)
- Dental services except for accidental traumatic injuries to sound natural teeth if treatment occurs within 24 hours of the accidental injury
- Conventional or surgical orthodontics
- Conventional or surgical orthognathics, unless the malocclusion is causing persistent trauma to the gums or palate not correctable by orthodontia.
- Cosmetic surgery
- Invitro fertilizations and embryo transport services; artificial insemination
- Transsexual surgery; reversal of sterilization
- Marriage or sex counseling
- Behavioral training, approaches that use classical or operant conditioning and/or interventions that focus on skills training (Examples include, but are not limited to, functional analysis, assertiveness training, smoking cessation, stress management, progressive muscle relaxation).
- Developmental testing after diagnosis.
- Remedial education and testing to evaluate school performance and/or diagnose or treat learning disabilities.
- Experimental psychiatric procedures, pharmacological regimen and associated health care services and/or those procedures that are not consistent with accepted standard medical practice or services requiring prior approval by any governmental authority prior to use where such approval has not been granted or services not approved for coverage by Medicare
- Long-term mental health or substance abuse services
- Podiatry services, unless Medically Necessary
- Routine foot care
- Experimental health care services and drugs
- Infertility drugs
- Chiropractic services
- Long-term physical, speech, hearing and occupational therapy and rehabilitation
- Vision care; Eye exams for contact lenses or their fitting; eyeglasses
- Hearing aids
- Services connected with Temporomandibular Joint Dysfunction
- Over-the-counter (OTC) drugs and supplies except those indicated as OTC Select
- Non-sedating antihistamines or low-sedating antihistamines
- Drugs used for the treatment of sexual dysfunction
- Family planning services including testing and treatment
- Sterilization procedures
- Abortion services

Limitations

- If circumstances arise beyond the control of the Plan (e.g. major disasters, epidemics); services will be rendered only as practicable within the limitations of available facilities and personnel.
- Members must use the Plan's participating providers. These providers are subject to change from time to time, and the Plan does not guarantee the length of service for any of its participating providers.

Copays

Copays are to be paid at the time of your office visit or when other services are received.

If you have any questions call or write:
M•PLAN CUSTOMER SOLUTIONS CENTER
(317) 571-5320 or 1-800-81-MPlan (800-816-7526)
8802 N. Meridian Street, Suite 100
Indianapolis, Indiana 46260

This brochure describes the essential features of the benefit plan and is not intended to be a full description of benefits.
The complete program is described in your employers' Group Service Agreement.
Your Certificate of Coverage is a complete description of your benefits.